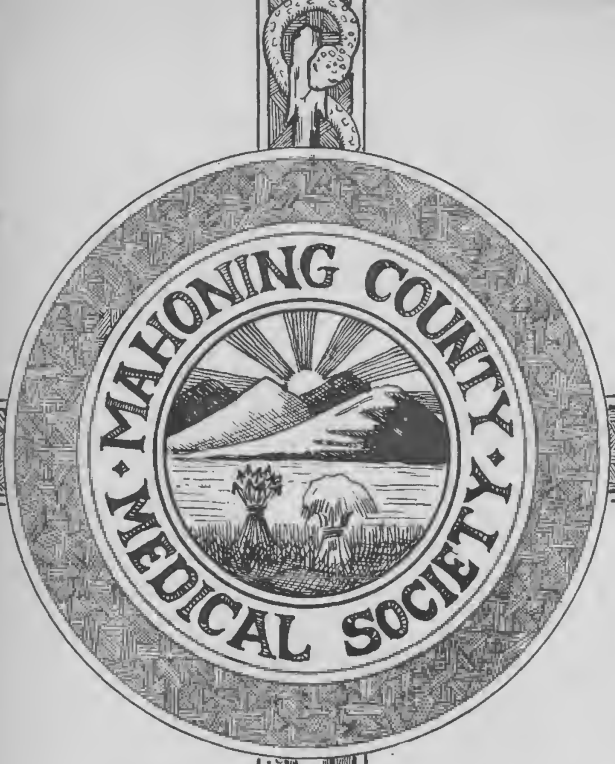

"Ez fer war, I call it murder—
There you hev it plain and flat,
I don't want to go no furder
Than my Testymint fer that."

—JAMES RUSSELL LOWELL.

BULLETIN

of the

Mahoning County Medical Society

Vol. IX No. 11
November 1939

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Vol. IX—No. 11

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November, 1939

ADVERTISERS' LIST

Patronize them—they make the "Bulletin" possible

It is a topic of conversation that getting into a **cold** car that has been parked **outside,** is **not** as wise as getting into a car that has been parked at the Central Square Garage, because the building is **heated.**

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BULLETIN of the . . . . . .
Mahoning County Medical Society

NOVEMBER 1939

Published monthly at
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Annual Subscription, $2.00.

WM. M. SKIPP, M. D., President — JOHN NOLL, M. D., Secretary
R. B. POLING, M. D., President-Elect — ELMER H. NAGEL, M. D., Treasurer
H. E. PATRICK, M. D., Editor

MEDICAL CALENDAR

November 21—Speaker, Dr. Jerome Selinger, Peptic Ulcer, Youngstown Club, 8:30 P. M.

December 19—Annual Business Meeting, Youngstown Club.

RADIO TALKS OVER WKBN FOR NOVEMBER

November 3—Dr. Richard Middleton: Premature Babies.

November 10—Dr. Lowendorf: Infantile Paralysis, the Chief Cause of Orthopedic Defects.

November 17—Dr. John Welter: The T. B. Patient, at Home and Abroad.

November 24—Dr. D. H. Smeltzer: Headache.

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ETHAN A. PAISLEY
BUSINESS MANAGER

PRESIDENT'S PAGE

The Ethics regulating the practice of medicine were developed out of the experience of our forefathers. We revere and cherish their code of ethics as handed down to us through the years.

The Ethics that medical men understand and practice are not found in any other profession or business; a code of conduct which considers service above self, a code which places the patient first in our thoughts and which dedicates the medical profession to the betterment of the public welfare.

Ethics may be of two kinds, those we practice and those we preach. Our Society has narrowed this distinction to the vanishing point. Rights of brother practitioners are recognized and respected. Innuendos by actions or word of mouth do not lay the ground work for malpractice suits. Fee splitting is an unknown factor in the relationship of family doctor and specialist.

So then at this Thanksgiving season we give thanks for our Code of Ethics which produces such a fine standard of conduct. Also we are thankful for the high professional attainment of our membership. We are thankful for the health of our community, a product of the efforts of our Society.

Lastly we are thankful that our sphere of activities has been cast in this Country of liberty, freedom and the right of free enterprise.

WM. M. SKIPP, M. D.,
President.

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PRIORITY IN THE USE OF TRANSFUSION IN AMERICA

Several months ago, there came into the Library of the Youngstown Hospital Association an old volume, No. 69, of The American Journal of the Medical Sciences, published in 1875. This was received through the Medical Library Association Exchange to build up a complete file of this publication. Because of its age, I was curious to see whereof our medical forefathers wrote, and was richly rewarded by unearthing an article by Dr. Wm. Pepper, attending physician to the University of Pennsylvania Hospital, on the use of transfusion in the treatment of pernicious anemia. This article caused me to wonder just when the use of blood as a therapeutic measure was first begun. Casual inquiry among my acquaintances gave me no enlightenment, however. But an answer to my query appeared in the September, 1938, issue of the Bulletin of the New York Academy of Medicine. As a part of the symposium on Blood and Blood-forming Organs given at the Academy fortnightly in 1937, Gertrude L. Annan, in charge of the Rare Books and History Rooms of the Academy Library, had compiled and exhibited a list of references pertaining to transfusion, which list was published in the Bulletin. To this list, I am indebted for the references and abstracts briefed below. However, no reference is made to Dr. Pepper's use of transfusion, as noted above.

The importance of the blood was appreciated as early as Biblical times. Leviticus, seventh chapter, second verse, reads, "Because the life of the flesh is in the blood and I have given it to you upon the altar to make an atonement for your souls; for it is the blood that maketh an atonement for the soul." Then there is mention of the use of blood as a restorative by Pliny and Celsus, only to be condemned by them. In the Metamorphorus by Ovid is this reference also: "Why, now, do ye hesitate and do nothing? Unsheath your swords and draw out the old blood, that I may fill the empty veins with the blood of youth." There seems to be a wide gap, from the fall of Roman culture to the seventeenth century, devoid of any reference to the subject. Then in 1615, Libavus says: "Let there be present a robust, healthy youth, full of lively blood. Let there come one exhausted in strength, weak, enervated, scarcely breathing. Let the master of the art have silver tubes that can be adapted one to the other; then let him open an artery of the healthy one, insert the tube and secure it. Next let him incise the artery of the patient and put into it the feminine tube. Now let him adapt the two tubes to each other and the arterial blood of the healthy one, warm and full of spirit, will leap into the sick one, and immediately will bring to him the fountain of life and will drive away all languor." Certainly, though the records are not available, men must have been thinking of transfusion, if such a prescience of the art of transfusion can there be sketched at that time.

Perhaps Harvey's discovery of the circulation, published in 1628, turned men's thoughts to the problem, but at any rate, the seventeenth century records several efforts to use blood as a therapeutic agent. In June, 1667, Jean Baptiste Denis, of Montpellier, physician to Louis XIV, transfused an insane man with sheep's blood. The individual subsequently died and Denis was the subject of much adverse criticism. Lamy and Pierre Petite argued against the procedure, but Denis was not without supporters in the persons of Claude Gadrois and Claude Tardi. The latter published a technique for direct transfusion of blood from man to man but there is no proof that the method was put to use. Gaspard de Gurye in a review of the question pointed out the dan-

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W. W. RICHARDSON, M. D., Medical Director
Formerly Chief Physician, State Hospital for Insane, Norristown, Pa.

gers in the use of incompatible blood. All of this controversy took place in 1667.

In England, Henry Oldenburg records in the Transactions of the Royal Society for 1665 that Christopher Wren, famous for his architectural achievements, had reported his discovery of this new experiment. An Italian physician of the time later contended that Wren had gotten his idea from him while on a trip to Italy. Richard Lower seems to have been the first to do animal to animal transfusion in England (1667).

The eighteenth century records but few contributions, these few dealing principally with animal experimentation.

In 1830, Johann Friedrick Diffenbach conducted experiments which led him to the conclusion that the blood of animals should not be injected into man. Sir Benjamin Ward Richardson in 1858 used ammonia to prevent coagulation. Arnold Edward Martin of Berlin reported in 1859, 57 cases of post-partum hemorrhage treated over the years 1824-57. Forty-five operations were reported as successful. Blasius in 1863 collected 116 cases, classifying 56 successful, 55 failures and 5 as doubtful. Interestingly enough we find John Braxton Hicks of version fame, and no doubt confronted with the problem of obstetrical hemorrhage, working upon the use of sodium phosphate as an anti-coagulant.

The first use of transfusion in America was ascribed by Dr. Roy D. McClure, in a historical sketch of transfusion appearing in the Johns Hopkins Hospital Bulletin for March, 1917, to Halstead. Halstead performed refusion in the treatment of CO_2 poisoning in 1884. However, I believe that the hitherto undiscovered publication by Pepper should be accorded that distinction.

Following Moss's monumental work on blood groupings in 1910, which work was based on Landsteiner's recognition of iso-agglutinins in the blood, the art, and hence the use of transfusion progressed rapidly.

Elsburg reported a simple cannula for direct transfusion in 1909. Brewer suggested paraffin tubes in that year also. Crile had published his method of direct transfusion in 1907. Kimpton and Brown introduced the paraffin glass tube method in 1913. Richard Weil in 1915 suggested the use of sodium citrate as an anti-coagulant and Unger's syringe method appeared the same year. These were all contributions by American physicians and the original articles are to be found in The Journal of the American Medical Association: Surgery, Gyn. & Obst.; and in the Annals of Surgery.

H. E. PATRICK, M. D.

PROPHETIC! WAS IT NOT?

This quotation, gleaned from Dr. Herrick's address, at the fiftieth anniversary of the opening of the Johns Hopkins Hospital. It is from the dedicatory address given by Thomas Hurley at the opening of Johns Hopkins University in 1876.

"You and your descendants have to ascertain whether this great mass will hold together under the forms of a republic, and the despotic reality of universal suffrage; whether state rights will hold out against centralisation, without separation; whether centralisation will get the better without actual or disguised monarchy; whether shifting corruption is better than a permanent bureaucracy; and as population thickens in your great cities, and the pressure of want is felt, the gaunt spectre of pauperism will stalk among you, and communism and socialism will claim to be heard. Truly America has a great future before her; great in toil, in care, and righteousness; great in shame if she fail."

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THE MEDICAL CRIER

A Page of Sidelights, News and Views in the Medical Field

• A nice, quiet affair that dinner dance was, oh yeah? That is if you were stone deaf and couldn't hear nothin'. The boys' wives must have given them all orders before hand to circulate around, dance with everybody and liven up the party. At least they acted that way. About a hundred beautiful ladies were badly affected with vertigo for three days from being whirled around so much. And the Paul Joneses—did the bald heads get a break there! Why do they always call out "first choice for the bald heads?" Do they think that's the only chance they get? Take it from an old timer, there are plenty of ways besides having good looks to attract the women, and do we know all the tricks! And how Ruth Autenreith's band did swing out. Those rug cutters just couldn't help getting that way. Well, no use trying to tell about it. You were all there, and you know what a grand good time it was. Come again soon, dinner-dance!

• Walter Stewart's economics committee has asked us to compile a table of costs of ordinary care of fifty average representative families. These accounts, picked at random from one doctor's files, produced figures which were surprising to him. Children in his families numbered from one to six but the average in all fifty was just short of two. It seems there is a preponderance of one-child families. Cost of one year's service to these families was $28.12 and of this cost $27.44 was paid. Of course, it is inaccurate to generalize from such a small sample, but it will be interesting for the committee to compile figures from say, two hundred doctors reporting on a thousand families. Costs of medical care have been estimated and generally accepted as being in the neighborhood of $60.00 per year. That figure includes medical care, hospitalization, medicine, patent medicines, irregular practitioners and everything connected with treatment of sickness; but it also includes the general public, many of whom had no need for medical care over the given period. Figures collected from doctor's patients will represent costs to those who actually experienced sickness and received treatment for it. If the figures quoted above are anywhere near the average for other doctors, then less than half of the cost of treating illness is in ordinary home and office care.

• Why all this hullabaloo about freshness? Bread is rushed from the bakery to be consumed fresh the same day, coffee is rushed "roaster fresh" from the ovens with the date on the package. Chocolates, cigarettes, fruits and vegetables receive all the aids of modern transportation to rush them to the avid consumer before they acquire any taint of age. In certain perishable goods such care is highly desirable, but we still get eggs and turkeys from cold storage that no one would care to date. Ageing in many foods imparts flavor and in some is absolutely necessary. Who wants fresh wine or cheese? The best ham we ever ate was six years old. Fresh bread is pale, doughy and limp, too weak or ashamed to stand on its own feet and claim its place as the staff of life. Give us bread that has body and fulness, that shrinks not away from the touch of butter and reverts not back to the primitive dough at the onslought of rennin and pepsin. Give us cheese that has lain in some cavern while nature's mould has performed its chemistry. Freshness can never make up for lack of quality in food, in ideas or in men.

• The passing of our good friend "Ike" Yengling caused sadness to many of us who knew him as hospital druggist, hospital superintendent, maker of Paraeusal and all around

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good sport. A devotee of tennis and golf, ardent supporter of Ohio State in football, he was the source of many a merry tale around the Youngstown Hospital. Along with the late Dr. C. C. Booth whose inventive genius is tradition, he developed Paraeusal—a compound the euphonious name of which was derived from its content of paraffine oil, eucalyptus and salicylic acid. Many disappointing experiments were conducted in the old pharmacy at the South Side Unit before the stubborn salicylic acid could be gotten into a stable solution in its oily vehicle, but having succeeded, his enthusiasm for his product has never been abated.

As Superintendent during the trying days of the immediate Post-war depression he was often discouraged and when he left the post for the management of his own store, it was with distinct relief. But his interest in the members of the Staff and his other medical friends continued to his last illness. We shall miss stopping in to see him, to hear a good story, and to reminisce over the old days.

—J. L. F.

PANACEAS

Doctors, like other people, are subjected to a great deal of sales pressure and commercial propaganda. We are constantly bombarded with circulars, advertising matter, free samples and personal calls of detail men all making claims—some of them rather extravagant — for the products which they are plugging.

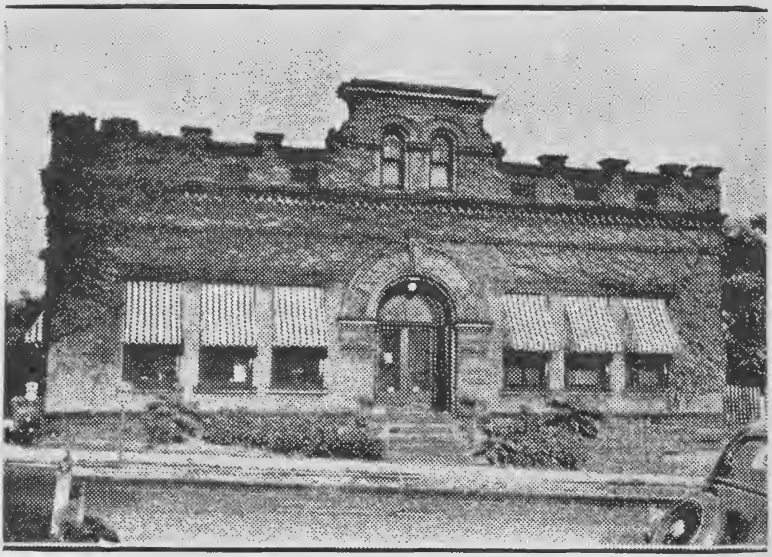
Being human, it is sometimes difficult to resist the temptation of adding some promising new drug or therapeutic agent to our armamentarium. We are more likely to play with new things when we are young; as we ripen in practice we learn to listen to the memorized enthusiasms of the detail men and to read the glowing accounts of the literature with mental reservation. We take their samples, look over the literature and say to ourselves "let someone else try it first."

This does not mean that we have closed our minds to medical progress. On the contrary, experience has taught us that it is best to wait until the newer remedies and apparatus have been tried in laboratories, hospitals and other institutions equipped for conducting scientifically controlled experiments. It will be time enough to accept them after they are proven. For we have seen methods and drugs "par excellence" have a tremendous vogue for a time, only to be discarded and forgotten. And so, as we go along, we become more conservative. We have learned that there are no panaceas.

One thought leads to another: There is an analogy between the practice of medicine and world conditions in general. In every country, including our own, there are those who offer political and economic panaceas. However attractive they may seem, they are unproven theories. Indeed, some nations have succumbed to shrill pied pipers and crackpot theorists, who have thrown overboard tried and established methods and are staking everything on doubtful ideological nostrums.

The result—we are living in a very sick world. So sick that a few more doses of the new remedies may destroy our entire civilization.

Let us hope that the doctors in charge of the destinies of nations will come to their senses before it is too late. Perhaps it would be even better if the patient himself, the people, were to discover that beneath the sugar coating of the new pills there is poison, and fire the crackbrained doctors. For sooner or later they must realize that we cannot discard our accepted and tried though not infallible remedies, for new fangled and unproven panaceas. Or is it too much to hope for? —L. S. D.



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VITAMINS

Through the mediums of the press, radio and the mails, the laity and profession are being urged to the wider use of various vitamin preparations. In the face of this highly organized propaganda to enhance sales, it might be well to present in summary form just what is known regarding the therapeutic activity of the more common vitamins.

Dr. Fishbein, in an introductory article to a series of papers regarding vitamins appearing in the Journal of the American Medical Association, beginning in the February 19th, 1938, issue, has presented the criteria set up for the acceptance of vitamin preparations by the Council on Pharmacy and Chemistry. We quote from Dr. Fishbein's article:

VITAMIN A

Allowable Claims.—1. Evidence for the existence of vitamin A and its role in human nutrition is based on the fact that a characteristic eye disease, usually called xerophthalmia, results from a deficiency of this vitamin.

2. It is generally agreed that the first symptom or at least one of the first clinical symptoms of vitamin A deficiency is night-blindness, or nyctalopia. For this type of night blindness vitamin A is a specific. Cases of nyctalopia exist which do not respond to treatment with vitamin A. These may be due to congenital defects or to other diseases than avitaminosis "A."

3. Present indications are that vitamin A is an aid toward the establishing of resistance of the body to infections in general only when there has been an exhaustion of body reserves of the vitamin and the ingestion of vitamin A is inadequate. It certainly has not been shown to be specific in the prevention of colds, influenza and such infections, nor has it been demonstrated that ingestion of vitamin A far in excess of that necessary for normal body function and readily obtained from a properly selected diet is an aid in preventing various types of infections.

4. A deficiency of vitamin A results in a retardation of growth when body stores of the vitamin have been depleted, but it must be borne in mind that vitamin A is no more important in contributing to normal growth than any one of the other vitamins, the essential mineral elements, or amino acids. Statements conveying the impression that vitamin A is more important in promoting growth than other food essentials are therefore considered misleading and objectionable.

5. There is at the present time inadequate evidence to warrant the claim that the ingestion of sufficient vitamin A will prevent the formation of renal calculi in man.

VITAMIN B_1: THIAMIN CHLORIDE

Allowable Claims.—1. *Vitamin B_1 is of value in correcting and preventing beriberi.*

The consensus of the students of beriberi is that this disease is due primarily to an insufficient supply of vitamin B_1. There are conditions which probably could be designated at "latent beriberi"; it does not seem wise at this time to attempt the formulation of a definite statement covering such conditions other than that presented in item 7.

2. *Vitamin B_1 may be cited as of value in correcting and preventing anorexia of dietary origin in certain cases.*

There are many causes of anorexia, some referable to infections and the reactions thereto, others to organic disorders, and still others related to faulty diet. Where there is no rather obvious cause of anorexia in question, other than a possible dietary one, it is permissible to claim that vitamin B_1 may be of therapeutic value when the condition to be treated is due to a deficiency of that vitamin.

3. *Vitamin B_1 is of value in securing optimal growth of infants and children.*

Citations in the literature support the claim that a suboptimal supply of vitamin B_1 results in limitation of growth.

4. *Because vitamin B_1 is a dietary essential its administration in concentrated form is of value in some conditions in which difficulty in utilizing ordinary foods in the usual way is encountered.*

The present status of research on the clinical use of vitamin B_1 for specific diseases other than beriberi and for infant feeding is such that definite claims for therapeutic value in relation to such diseases cannot be recognized. Its use may be indicated, however, in such restricted conditions as pernicious vomiting of pregnancy,

tube feedings through a jejunal fistula, and the like, because the above permitted statement applies to such conditions and gives an intelligent basis for such therapy.

5. Claims for concentrates of vitamin B_1 offered for clinical use should state the potency in terms of the International unit. The term "concentrate" or a synonym will not be recognized if the product does not exceed a potency of 25 International units per gram (or per cubic centimeter), or if it is a natural product which may have been subjected to a process of dehydration.

6. In connection with medicinal foods acceptable for N. N. R., the claim that a food is valuable because of its vitamin B_1 content may be made only if it provides in the quantity of food consumed daily at least 200 units of vitamin B_1.

Any food preparation having less than such an amount cannot be regarded as a noteworthy medicinal source of the vitamin. In the light of present knowledge the daily requirement for vitamin B_1 appears to be not less than 50 units (International) for the infant and 200 units (International) for the adult.

7. There are many experimental indications in the literature suggesting other possible functions of vitamin B_1, e. g., an influence on intestinal mortility and neuritis of various types, and also indications of greatly augmented requirements when metabolism is increased as in hyperthyroidism, neuritis of various types, or infections. It seems too early to permit advertising claims for these conditions.

VITAMIN C: CEVITAMIC ACID

Allowable Claims.—1. Definite claims for the therapeutic value of vitamin C should be permitted only in relation to scurvy until further clinical or experimental evidence has substantiated its usefulness in other states.

2. Vitamin C is acceptable for the correction and prevention of scurvy. This effect has been established experimentally and by clinical investigation.

3. It may be permissible under certain conditions to refer to the therapeutic value of vitamin C in early and latent scurvy. Convincing clinical evidence has established that this state does occur. It would be well to emphasize the fact that the diagnosis rests, however, on the basis of roentgenologic evidences in the long bones, and possibly failure to excrete an optimum amount of cevitamic acid in the urine.

4. Dental caries, pyorrhea, certain gum infections, anorexia, anemia, undernutrition and infection alone are not in themselves sufficient indications of vitamin C deficiency but according to experimental and clinical investigation they may be concomitant signs of vitamin C deficiency. Therefore, it would be permissible to accept the claim for the therapeutic value of vitamin C in these symptomatic conditions *only when* it is definitely stated that they are the consequences of a deficiency or suboptimal amount of vitamin C or when there is a pathologic interference with assimilation of the amount necessary for the preservation of health.

5. Unless more convincing evidence is present than is now available, no claim referable to the anti-infective effect of vitamin C will be recognized. Secondary infections are characteristic of disturbances of nutrition, particularly in all vitamin deficiency diseases. It has not been established that vitamin C has a therapeutic effect which directly influences associated secondary infections in scurvy.

6. Because vitamin C is a dietary essential, its administration in concentrated form is of value in conditions where difficulty in introducing orally or utilizing ordinary foods in the usual way is encountered. Vitamin C (cevitamic acid) is accepted as an essential dietary constituent in infant feeding but it should not be accepted for use in the treatment of diseases except according to the conditions mentioned above. It is generally administered in the form of a vitamin C carrying juice. When there is persistent vomiting, diarrhea, or any other condition preventing its utilization in proper amounts it should be permissible to give vitamin C parenterally in concentrated form as sodium cevitamate.

7. Concentrates of vitamin C offered for clinical use must state the potency in terms of the International unit. The International unit for vitamin C, which was formerly defined as the vitamin C activity of 0.1 cc. of lemon juice, has now been defined as the vitamin C activity of 0.05 mg. of l-cevitamic acid (ascorbic acid). This is the quantity of l-cevitamic acid usually found in 0.1 cc. of lemon juice.

8. The claim that a food is valuable because of its vitamin C content should be permitted only if it provides a daily intake of at least 250 units of vitamin C.

9. A reasonable general statement regarding allowable claims for vitamin C would be as follows:

(Continued on Page 323)

Scientific Program

Tuesday, November 21st, 1939

•

Guest Speaker

JEROME SELINGER, M. D.

from

NEW YORK POSTGRADUATE SCHOOL

•

Subject

PEPTIC ULCER

•

Youngstown Club

8:30 P. M.

•

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VITAMINS

(Continued from Page 320)

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2. Direct exposure of the skin to ultraviolet light from the sun or from artificial sources results in the formation of vitamin D within the organism but the Council cannot recognize statements or implications that vitamin D has all beneficial effects of exposure to sunshine.

3. There is clinical evidence to justify the statement that vitamin D plays an important role in tooth formation and maintenance of normal tooth structure, but there is no warrant for the claim that adequate vitamin D intake will insure normal tooth structure or that adequate vitamin D intake will prevent dental caries.

4. Animal experimentation has shown that correction of an inadequate intake of vitamin D results in the more economical utilization of calcium and phosphorus and also that the undesirable effects of improper ratios of calcium and phosphorus in the diet can largely be overcome by normal intake of vitamin D. The importance of these observations in their application to man is not entirely apparent because of the lack of adequate clinical evidence showing the availability of different forms of calcium and phosphorus, but it may be stated that vitamin D has a favorable influence on calcium and phosphorus metabolism.

5. The vitamin D requirement is greatest during the period of infancy. Beyond the age of infancy the exact vitamin D requirement of man under any specified conditions is not known but it appears that the requirement during pregnancy and lactation is increased.

SECRETARY'S REPORT

The regular Council meeting was held at the office of the Secretary, October 2nd, 1939.

The regular October meeting of the Society was held on Tuesday evening, October 17th, at the Youngstown Club.

The Scientific Program was presented by Dr. Louis H. Newburg, Professor of Clinical Investigation and Professor of Medicine at the Medical College of the University of Michigan. His subject was "Diabetes."

He discussed the subject from the practical viewpoints of correct diagnosis and correct treatment. He stressed the necessity of rightly interpreting the glucose tolerance curve in a given patient suspected of having diabetes. The level of the fasting blood sugar portion of the curve must be noted carefully. Underfeeding with emaciation may give a normal fasting level with an otherwise diabetic-like curve. These individuals will promptly return to a normal curve with adequate diet. They are therefor not true diabetics. Likewise obesity will

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often give a normal fasting blood sugar level in a curve otherwise high. These patients when placed upon an ordinary reduction diet will soon have a normal curve as the weight becomes normal. The great frequency of obesity glycosuria was illustrated in a series of 370 cases treated at Michigan in 1936, 43.8% of which were merely obesity glycosuria. Dr. Newburg than showed by charts that the obese can oxidize glucose as well as the juvenile diabetic. This rules out our old conception that diabetics cannot oxidize glucose and leaves us stranded as to etiology of the disease. He did admit that the total diabetic cannot oxidize glucose but stressed the fact that this type of patient is exceedingly rare.

In the treatment of the disease Dr. Newburg stressed the fact that underfeeding is wrong because it interferes with the function of the pancreas to make insulin. It requires 150 grams of carbohydrates daily to permit normal utilization therefor give this amount and if necessary cover it with insulin. The speaker then added that 200 grams might be given but that 400 to 500 grams is absolutely wrong.

In closing he stressed that three types of individuals must be excluded before correctly diagnosing diabetes mellitus, namely,

1. Underfed glycosuria,

2. Renal glycosuria,

3. Obese people who have interference with carbohydrate metabolism.

Following the Scientific Program Dr. Skipp discussed the advisability of defeating the Bigelow Amendments at the polls. Pamphlets from the State Association Office were passed out by the Secretary to each member.

A motion was made, seconded and duly passed that the Society gives unanimous consent to each Section of the Amendments and Additions to the Constitution and By-Laws as read.

Dr. Claude Norris then read each revised Section with comment.

Following the reading a motion was made, seconded and duly passed that the Amendments and Additions to the Constitution and By-Laws be approved as read.

The meeting adjourned at 11:00 p. m.

DR. JOHN NOLL, *Secretary.*

Columbus Meeting of the A. A. A. S. Next Month

The winter meeting of the American Association for the Advancement of Science will be held in Columbus, Ohio, December 27, 1939, to January 2, 1940. Section N—Medicine and the Medical Sciences—will present a series of comprehensive symposia in the fields of hematology and cardiology. On the afternoon of December 27th the opening session will deal with the more recent and significant advances in hematology with invited speakers outstanding in their respective fields of investigation. On the 28th, 29th, and 30th, each morning and afternoon will be devoted to the presentation of some phase of modern cardiology by leading authorities from throughout the country.

EVERY PHYSICIAN IS CORDIALLY INVITED TO ATTEND THESE SESSIONS WHETHER HE BE A FELLOW OF THE ASSOCIATION OR NOT.

Dr. Carl J. Wiggers, Western Reserve Medical School, Cleveland, Ohio, is Vice-President for Section N this year and in charge of the cardiologic symposia, while Dr. C. A. Doan of Ohio State University, is the local Chairman on arrangements for the medical meetings, and has planned the hematologic program.

The exact location of the sessions, and the detailed program will appear in the December Journal.

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THE AUTOPSY AND THE GENERAL PRACTITIONER

It is often said, and truly, that the scientific rating of a hospital can be estimated by the percentage of autopsies in comparison with the number of deaths in the institution. Osler well exemplified the fact that the doctor who witnesses the highest possible percentage of autopsies upon his fatal cases is all the better for doing so. And that statement is just as valid for the surgeon as for the internist. It can be equally well applied to the general practitioner. Certain specialties deal with illnesses which are largely minor in character, whilst others are concerned almost exclusively with the most serious diseases. The latter sort of disturbance is just as important for the general practitioner who sees proportionately few as for that specialist who is confronted with many. The specialist who witnesses many autopsies enlarges his knowledge of his field. The general practitioner who does likewise, learns much by the same method but in a larger and more diversified field.

There is never an autopsy that does not teach something to those with scientific spirit and desire to learn. Naturally this statement depends, for its verification, upon proper and adequate performance of the postmortem examination. It must be done with all consideration for doctor, family and friends. The technic and the repair must be meticulously careful. He who makes the examination must be well trained in morbid anatomic diagnosis. On the basis of abnormal form, he must think in terms of altered function and clinical manifestation. True, the autopsy teaches, but the examiner must be the thoughtful interpreter, acting as consultant to the clinician and capable of putting the disclosures into understandable phraseology. The autopsy is not to be a slap-dash cutting into a dead body, hasty and cursory, with a casual look at certain viscera. It must be a careful scientific inquiry into the conditions found in a patient recently alive and suffering. It is no mere anatomic dissection but rather a coöperative study with the clinician to discover the processes and effects of disease. Sometimes it may fail to uncover the exact cause of death, but to the trained eye it discloses lesions of the utmost interest to that doctor who has examined the patient thoroughly, arrived at a logical diagnosis and has instituted rational treatment.

Human nature being what it is, there are several kinds of doctor. Some have little inclination to delve exhaustively into questions of diagnosis and, trusting to the healing powers of nature, are content if they can make the patient comfortable. If after death, the family, as is occasionally true, wishes to have an autopsy, they will make the arrangements, but they do not urge it, may not ask for it and indeed in rare instances may even oppose it. Some spend much time and effort on "interesting cases" and seek autopsy if death occurs; they fail to realize that all cases have their interesting and instructive features. Some look upon all their patients as genuine problems in diagnosis and treatment; they are almost as much disappointed at failure to obtain permission for an autopsy as they are distressed at the death. General practitioners fall into the same categories, but in different proportions from the specialists, more perhaps into the first group and fewer into the last. In the second division are those general practitioners who request autopsy only on those of their fatal cases that have been seen by specialist consultants. If the situation could be changed so that all of us belonged in the third category, Medicine would benefit greatly. The Bourbons of our profession, who learn nothing and forget nothing, we have always with us, but may their number ever grow less! Medicine can profit by their complete elimination (or

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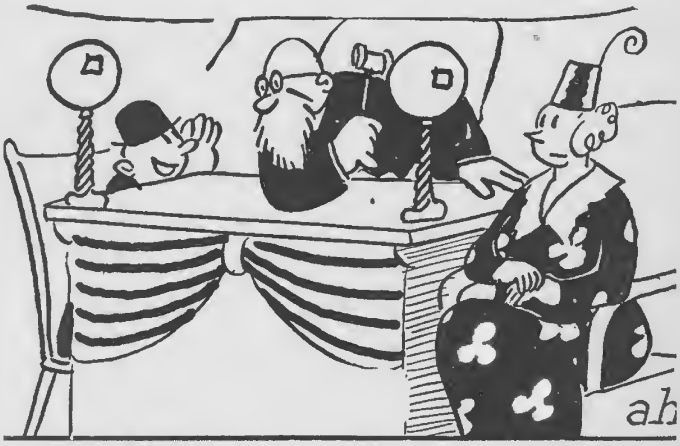

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should it be extermination?) from our midst.

Happily, most doctors in these days are situated near medical centers where competent pathologists are available. By all means, the trained pathologist is the one who should perform the autopsy and interpret the observations. For the most part, neither the clinical specialist nor the general practitioner is a pathologic anatomist and if the autopsy is to be of real use, someone who knows all about the job had better be on hand. A clinical diagnosis, be it good or bad, cannot be verified or denied by an anatomical diagnosis that is not of the best. What can be done then if there be no pathologist at hand? The answer is simple enough. Some local man should obtain training, and this can be done at little cost of time, so that he can record the relations of organs, remove them and satisfactorily repair the body. If a pathologist be near by so that the organs can be received in the fresh state, they and the record should be sent to him immediately. Otherwise, sections of the organs, large enough to give a good picture of the whole and properly fixed, should be sent together with the record. Unless the pathologic diagnosis be accurate, the autopsy is practically useless. Unless the body be properly repaired, the whole structure of Medicine may be injured. A poor repair after autopsy may do as much or even more harm to the profession than a bungled surgical operation.

The doctor devoted to his patients and his profession can fulfill his destiny and that of his calling by insuring, in as far as is at all possible, autopsy on all of his patients who die. The dead body can serve no better purpose than to be used for the education of the doctor, the advancement of Medicine and the information of the surviving relatives.

HOWARD T. KARSNER.
Digest of Treatment.

LET THE DEAD PAST BURY THE FUTURE

Some years ago an author, whose name I cannot recall, wrote a two-volume work wherein he analyzed the factors common to all civilizations in an endeavor to find a common denominator, as it were, that was applicable to the rise and fall of the successive civilizations that the world has experienced. He came to the conclusion that the factor which brought about the rise of a tribe or nation from savagery to civilization was the impression of maternity upon all women. As the tribe or nation progressed, certain women were able by means of their superior intellect to acquire wealth, become independent of the male for support and to withdraw themselves from the function of reproduction. According to our author, it was at this point that the decline of that particular civilization began.

Assuming that there is a modicum of truth in the theory, then the United States has reached its zenith. Recent critical surveys of our birth rate and the distribution of births throughout the social order, show that the average rate of births at the present time is 25% short of replacement needs to maintain our present population; and that the replacement rate in the professional and well-to-do groups is but 50%, whereas in the share-cropper class, and among the Mexicans and Indians within our borders, the rate of replacement is 120%.

The wide difference between the replacement rates of the two classes cited is felt to be due to the greater knowledge of contraceptive measures possessed by the former group. Manifestly, the physician, in combating the lowering birth rate with its disparity in quality, should not extend the knowledge of contraceptive to the

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second group, but could more properly concern himself in an endeavor to point out to those most suited and able the desirability of rearing sufficient children per family to maintain the replacement rate. Modern medical skill and science have greatly lessened the travails of reproduction, so there can no longer be that excuse to avoid maternity. The future of our "noble experiment" is decidedly up to the women of means and intelligence, and the result of their failure to have met the problem adequately in the immediate past is rushing at us in an alarming manner in the falling birth rate of the nation.

H. E. PATRICK, M. D.

THE DINNER DANCE

By CHARLIE HORSE

The Child of Music and of Love (*vide* John Davies, *Orchestra,* St. 96) viz., "Dancing," took many medicos in tow, on Saturday evening, October 21st. This was the Second Annual Dinner Dance of the Mahoning County Medical Society, and it was put on at the Southern Hills Country Club.

Testifying to the favor with which this function caught the fancy of everybody, present were 91 couples. They were beyond cavil delighted—that is, if the usual symptoms of delight are reliable. It was fun, free and kind and jolly. It was one touch that made the whole world kin—of the family of Charlie Horse! Oh, not really the ladies — they could dance forever—apparently—and be just as fresh-lookin'! But it was the next day that "we fellas" found out about our numerous infirmities.

Near as memory serves, doings began about eight o'clock, with dinner —and lasted, with dancing and all, until a long time after. And the dinner—it was good old steak and all the trimmin's. The tables were diked out with shades of gold and bronze chrysanthemums, oak leaves, huckleberry, and maidenhair fern—and you can just go right out and tell the whole A. M. A., they were beautiful!

Prizes went to three of the lovely ladies—(believe it, all of our girls were the real prizes, what gorgeous gowns, oh-me-oh-my!) Dr. Stefanski held the box that held the lucky numbers and Mrs. Heberding drew the lucky numbers, which determined that the winners were Mrs. Rothrock, Mrs. McNamara, and Mrs. Brown. They got some very, very nice pretties!

The affair was a brilliant success because of the perfect performance of such people as Ruth Autenreith and her orchestra; Mr. Miller, manager of Southern Hills, whose every effort was toward the happiness of the guests; the fine coöperation of the men who sold tickets; the corps of Committee assistants and the Social Chairman, Dr. Nesbit. To each of them all those present are deeply indebted for a distinguished and memorable event.

The lowly interne bids fair to become of great importance. Eight hundred hospitals in the United States are lacking in internes and feel that their service and usefulness to their communities are being curtailed.

Police officials, either city or state, are frequently the first to arrive at the scene of a serious accident. Upon the proper handling and transporting of persons with injuries of the neck and spine may depend a good or bad outcome or may indeed determine between life and death. The society could well serve the community by organizing a group of surgeons and orthopedists, and invite the police department to attend a series of lectures and demonstrations in the proper methods of handling injured persons.

On the wall of the Institute of Anatomy in Wurtzburg appears this motto: "Mortui vivos docent."

A RESUSCITATION SQUAD IN OUR HOSPITALS

By CLAUDE S. BECK, M. D.
Bulletin of The Academy of Medicine of Cleveland

An effective method for defibrillation of the human ventricles has come into existence and is ready for application. It is reported here in the hope that someone in our Cleveland hospitals will be the first to apply it successfully to a human patient.

The procedure as it now exists is the product of several investigations. It seems that the first experiments to stop fibrillation of the ventricles by passing an electric current through the heart were briefly reported by Prevost and Battelli in 1899. Within the last five or ten years, Hooker of Baltimore and Wiggers of Cleveland carried out extensive investigations on this subject. They brought the method to a point which in our hands was successful in about fifty per cent of the experiments on dogs. It was not always successful because the fibrillary movements could not always be abolished by the current. If the fibrillary movements persisted in one small part of the myocardium during the passage of the current, these movements would spread immediately after the current was broken. In the presence of fibrillation in any part of the ventricles it is impossible to restore the coördinated heat. Three years ago Mautz of Cleveland demonstrated that procaine applied directly to the heart reduced the irritability of the heart. It was but a natural step to determine whether this drug would help abolish all fibrillary movements when it was combined with the electric current. It worked. Not only that but experience has shown that the method was always effective in stopping the fibrillation and making restoration of the coördinated heart beat possible. It now becomes the surgeon's duty to make this more than a laboratory demonstration in physiology. It must be applied to the human patient. Successful application will require preparation and training on the part of the surgeon. Because of this it seems advisable to have in every hospital a Resuscitation Squad trained to act in the emergency.

Resuscitation is possible in any patient whose pulse and respiration suddenly cease during operation, provided that he is free from heart disease, chronic disease or infection. Where the tragedy occurs in the operating room equipment for immediate action is available. If it occurs outside the operating room, success is scarcely possible. These requirements reduce the possibilities to about two or three patients a year in any large hospital.

The procedure consists of two stages. The first stage is by the anesthetist and by the surgeon who are present when respiration ceases or when the pulse disappears. It is necessary to get oxygen to the brain. Delay in doing this must not exceed three to five minutes. Action must be forthright, almost reflex, and not the product of deliberation. The anesthetist aerates the lungs with a mechanical respirator designed for the purpose. The Drinker respirator cannot be used for this purpose. The surgeon opens the chest with an intercostal incision, opens the pericardium and massages the heart. The blood pressure goes up to about 60 m.m. Hg. Oxygen is carried from the lungs to the brain. The emergency is now over.

The second stage is by someone from the Resuscitation Squad. Time can be taken for this person to be summoned. This stage concerns the heart—defibrillation—standstill—restoration of the coördinated beat. Procaine, epinephrine, and calcium chloride are the drugs that are used. The current is ordinary alternating electric light current cut down to one and one-half amperes. The electrodes placed on the heart are large. Instruction for the second stage should be obtained in the experimental laboratory.

When the pumping action of the heart ceases and the arterial pressure disappears, the ventricles either come to a complete standstill or go into incoördinated fibrillary twitchings for a while before every vestige of movement disappears. Each of these means death unless a coördinated contraction is restored to the heart. A coördinated beat has been restored successfully if the heart is in standstill and not in fibrillation. Prior to the development of this method of resuscitation, fibrillation of the human ventricles has been fatal. The method is ready for application. The first successful application to a human patient will mark a step in advance.

"IT SHALL NOT HAPPEN AGAIN"

By CRAIG THOMPSON
Member of the Reportorial Staff of the New York Times

Three men who made rich contributions to their own world and to that of those who followed them each died of tuberculosis and each died too soon. They were Frederick Chopin, the pianist and composer; Anton Chekhov, the dramatist and author; and Sidney Lanier, the poet and musician.

Taking the last first, it is recorded of Lanier that, lying in bed with his beard flowing over the coverlet, his eyes glittering beneath an ivory brow and his body burning with a temperature of 104 degrees, he dictated his greatest poem, "Sunrise." In it a man made helpless by a scourge, filled with the overpowering desire to go on living and creating, found courage to ask of a tree:

". . . with your myriad palms
upturned in the air,
Pray me a myriad prayer."

Too soon thereafter he died, on September 7, 1881, not then 40 years of age.

And Chekhov. He wrote "The Cherry Orchard" and filled it with the anguish of frustrate youth and the spirit of decadent middle-age and told it in universal terms, so that it became an ageless play in all languages. And he did this in the year that he died. That was 1904 and he was 44.

And Chopin, who compressed into music the rolling thunder and the ruthless fury of the French revolution, did it, also, within the year that he died. He, like Lanier, was 39 and the scourge claimed him on March 1, 1849.

Three tombstones bearing the death dates of 1849, 1881, 1904. Three men, a Polish born Frenchman, a Russian and an American. One enemy—tuberculosis.

These three are not alone. The Bronte sisters lived in England. Charlotte Bronte gave the world "Jane Eyre," Emily, "Wuthering Heights," and Anne, "Agnes Grey." They, too, died too soon; Anne when she was 29, Emily when she was 30, and Charlotte at 39. There was a common cause. It was tuberculosis.

These are samples of mankind's tragic losses, a list that could be extended indefinitely. How much richer they might have made the world we all live in, had they gone on living, is speculation. In each there was an indomitable will to create, to pour forth the contents of human spirit that is the essence of human creation, which would not be quelled even by the long shadows that approaching death threw over them. As it is, they speak with added poignance of that simple family grief which comes with the death of any of those "flowers that grow between."

There is no unalterable need of this. Tuberculosis can be prevented and it can be controlled. The task is a great one requiring constant vigilance, constant service, and the constant support of those who, enlisting in this march of human progress, might well adopt as their battle cry, "It shall not happen again."

THE SEARCH FOR TRUTH

The growth of science has influenced the course of men's lives in two directions. It has given man greater power over the resources of nature and thus has raised his standard of material living; this is a direct result of discovery and of the application of knowledge. Its indirect result, a more general use of rational thinking, has been no less important though less spectacular, perhaps because its influence is slower. The great discoveries of Newton, though immediately only concerned with the laws of motion and physical force, by their simplicity and range united in men's thought the structure of the universe; what was true of a candle's beams must also be true of light from the sun and the most distant stars. There are no islands of autonomous local truth in a dividing sea of chaos, but one rule of law stretching to the boundary of human discernment and beyond it. The indirect effect of the realization of the unitary character of the universe was a confidence in reason in the face of the ever-prevalent human tendency to superstition, that expression of distorted emotional thinking. The spanning of the stretches of interstellar space by man's measuring devices strengthened his belief in the active power of his mind so that it did not quail before the apparently more elusive mysteries of his mental life. The realm of magic and superstition was attacked with a self-confidence previously lacking, and, in the age of reason, blind wonder at the terrifying incomprehensible gave place to a determination to clarify and map out, if only by slow stages, this last remaining *terra incognita*—man's too emotional ways of thought.

In the crisis now affecting us in the infancy of our civilisation we may perhaps learn something from the early development of science. We in England, and our colleagues in Germany, are faced with an enigma which each in his own way tends to answer with wishful thinking—what is going on in the mind in enemy countries. Between them and us stretches that most terrible of all barriers, a war frontier. The first assumption we have to make, if that gap is to be bridged, is that the laws of mental life in that unknown land are, like the physical laws, exactly the same as ours. It is a difficult assumption because as a result of war we are led all too readily to the illusion that the enemy on the outbreak of hostilities loses something of his humanity whereas we do not. The irrational notions we cherish during war, no doubt stimulated by the strain, are comparable to the emotional beliefs which the age of reason so largely dispelled from everyday life. It would now seem to us odd if someone said that an individual was possessed of a devil, because we cannot believe that an individual is subject to other influences than those of heredity and environment — and this holds for his highest ideals as well as his most degrading ideas. We neither exorcise the devil nor subject the possessed to torture, but study his mind and the forces which moulded it. This we can do because we believe in the constancy of mental reaction as we believe in the constancy of physical reaction. With nations it calls for an effort to retain the same objectivity which we now ordinarily apply to single human beings.

With the widening of the range of subjects to which we apply reason there is of course a narrowing of the fields in which our phantasies have free play, and one of these is nationality. Perhaps the task of this generation, a task thrust upon us all too quickly and forcibly by the rapidity and power of mechanical invention, is to clarify the emotional and political issues—they are surely inseparable—of our communal life as this affects us both as individuals and as nations. Political thought in Europe

today revolves round two major issues, nationality and the regulation of economic life. No nation now facing a crisis can consider these matters solved, nor can any of them impose their own solution upon another group with any prospect of permanence and success. A realisation of this should strengthen us to resist the egoism and ambition of tyrants, as it should also humble us before the no less gigantic task of fashioning the terms of armistice and peace.

The boundaries of our social and economic life are dissolving away as a result of man's increasing control over the forces of nature; the facility of contact in peace and in war will be a sorry gain if the minds of the nations are not prepared to consider the new responsibilities which improvement in communications inevitably brings in its train. Sooner or later, if the horror of war is not to devastate the whole of our civilisation, the nations will have to recognise that they cannot live in cultural islands of their own devising, separated by troubled seas of ignorance and suspicion, but will have to plan on a new basis for an era of neighbourliness. The recognition of the universality of natural law has two phases, that of matter and that of mind. An exclusive application to the first has imperilled civilisation; only application to the second will save it. We should no longer trust to the often blind and too often destructive guidance of our feelings, especially when we have power in our hands. Man's spirit has risen to great heights of constructiveness and some of his works bear the stamp of eternity and truth. Our precious heritage of culture calls not only for valour in arms for its protection but courage to refashion it as our increasing knowledge of our human weakness discloses the causes of the defects in its structure. The search for truth gives man fortitude and the reward of those who seek it is peace.

—*The Lancet.*

The Regular Monthly Meeting

of the

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Wednesday, November 15, 1939

8:30 P. M.

PROGRAM

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Professor of Pathological Obstetrics, Ohio State University

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"Two distinctive contributions by Ohioans to the Christmas Seal sale have been made this year to the tuberculosis campaign," said Dr. Charles A. Doan, president of the Ohio Public Health Association.

"Rockwell Kent, designer of this year's Christmas Seal, although born at Tarrytown, N. Y., traces his ancestors back to the original founders of Kent, Ohio.

"Professor W. W. Charters, author of the school health program to be used throughout the nation during the Fall months, is director of the bureau of educational research, Ohio State University.

"These facts make for more than ordinary interest on the part of all tuberculosis workers throughout Ohio," Dr. Doan said.

"Everywhere throughout the state increased interest and activity are noticeable on the part of the local organizations. They are imbued with a determination to take new citadels of the tubercle bacillues."

"Mr. Kent," stated Dr. Doan, "has given us in this year's Christmas Seal a realistic symbol of an angel with outstretched arm against a brilliant blue background. A large double-barred cross, international badge of the fight against tuberculosis, is prominently displayed. The Seal design may well be interpreted as a benediction upon the fight which has been carried on so successfully against tuberculosis during the past 33 years."

"I am sure," Dr. Doan stated, "that the people of Ohio are more interested today than ever before in the hope of a complete conquest of tuberculosis. To that end they will increase their generous support of tuberculosis work by the purchase of the colorful Christmas Seals for use on their Christmas mail and packages."

The thirty-third sale of Christmas Seals opens in Ohio December 1 and continues until Christmas Day.

C. B. Cassaday
PRESCRIPTIONIST
268 LINCOLN AVENUE
YOUNGSTOWN, OHIO
PHONE 40107

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A shockingly large amount of dust—literally hundreds of tons—is deposited annually over each square mile of the larger urban centers. The following figures, from independent studies made over a period of years, are not isolated examples but typical of the atmospheric pollution in large cities.[1]

	Tons of dust per sq. mi. annually
Baltimore	1800
Pittsburgh	1031
Salt Lake City	349
Cleveland	780
Washington	291

In many smaller communities even worse conditions may prevail under any of the following combinations: (1) soft coal, (2) low inland wind velocity, (3) concentrated manufacturing activity, (4) no zoning regulations, (5) no smoke abatement ordinances.

It is noteworthy that even a nonindustrial city such as Washington has so high an atmospheric pollution, due mainly to smoke from residences and office buildings.

This vast amount of soot and dust cuts off light. Shrader, Coblentz, and Korff, for instance, found that the amount of ultraviolet light in Baltimore was half that 10 miles from the center of the city.[1] Under such circumstances, to rely on winter sunbaths for the treatment of rickets may prove ineffective.

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*U.S.P. Minimum Standard. [1]U.S. Public Health Bulletin No. 224.

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